1. Briefly describe a future vision for a Missouri Health Information Exchange (HIE). What goals should be accomplished as Missouri develops a strategic roadmap for Health Information Technology (HIT) and Health Information Exchange (HIE) in the state?

- Exchange that will actually be used.
- 92% want narcotic prescription histories (92% of Family Practice Doctors)
- Embedded into workflow – integrate into existing systems
- Primary goal to improve patient care through improved qualities.
- The state will provide a framework to reduce redundant work and interfacing.
- A common standard that is open instead of vendor driven.
- Shared cost.
- Benefits quantification component.
- Not a silo initiative – consider how can integrate with other healthcare initiatives.
- Qualities:
- Interoperability – linked databases vs. centralized database, connectivity with PEHR security.
- Accessibility – input integrated into workflow/consumer access.
- Support innovation.
- Consumer broad/personal electronic health record.
- Goals:
- Realign ROI to provide benefit to payers/providers (Business model must reward providers to improve care through HIT/HIE i.e. reward coordination of care)
- Effective transition of care across multiple environments/providers = inclusive of all health info.
- Single point of data exchange, which serves as a linkage.
- Meaningful use – info shared access types of providers; consumers access; enhance continuity of care; support competitive effectiveness; research regarding outcomes – enhance quality of care & reduce cost by incentivizing (pay for performance) for most effective approach.
- Corrections need a web base system.
- A health care exchange system where we can share information with private insured people and public insured people (groups this would include physicians, schools, state

- departments, including corrections & mental health and health departments. As well as nation-wide.
- Get it done so providers can access incentives.
- True interoperability – PLEASE!!
- Result in better outcomes – improve quality improve safety.
- Use information to help do provider placement planning – put providers where needed
- Access – HIE needs to be all-inclusive – all patients, insured & uninsured, etc.
- Don't stop with HIT/HIE – mover toward PHR – access to a patient's own records in a consumer friendly format.
- Use information to help with public health needs.
- Go beyond medical- integrate oral health, mental health, pharmacy – all health professions share information.
- Consideration for opt out on an individual basis.
- One master patient index for the entire state.
- Competing vendors and models must be standardized, ensure systems interface with each other.
- Behavioral health, substance abuse, and developmental disabilities should be included.
- Meet the needs of the local provider first, affordable, and timely.
- Data be proven to be secure.
- A common ID for everyone.
- All hospital/medical records should be available electronically.
- All health care entities connected
- State wide MPI
- Infrastructure does not need to be local – affordability
- Want to be able to see all encounters on patient who presents to an ED.
- Has to be about the patient – care management/coordination
- Goal – Not without providers participating in HIE by 20XX.
- The state itself needs to become more integrated electronically (CIMOR, MOSAIC, Cyber Access, APS)

- HIE should be based on clinically authenticated data, not claims data.
- Personal health record – patient needs a view into the HIE.
- Amend legislation around privacy to allow interchange with behavioral health and alcohol/drug abuse.
- Secure messaging within the HIE.
- Should be able to share immunizations.
- Centralized repository.
- Need to connect to the VA, DOD, and other federal medical record systems.
- Integrate all existing groups that are out there.
- LACY (St. Joe), IHN (St. Louis)? (KC), FQHC Data warehouse.
- Insurance companies have data on the insured population – Get them involved to provide the health information for that population.
- Medicaid, public systems. Don't reinvent the wheel – get info from existing systems instead of a central repository
- Make an extra effort to include the rural areas possibly by hub connectors to
- Need to make sure this is done to improve patient quality & outcomes & not just implement to implement.
- Four regional HIE's each maintained by regional organizations to ensure an easier implementation. All four will then come together to the fifth HIE for a statewide exchange.
- Goals should be a main vision of statewide, but keep in mind it will not happen overnight, that is why doing regionals would be beneficial.
- Realizing that it does not have to be a large organization who carries out the plan because sometimes larger organizations have too many politics and which can add a lot of time & lose site of the common goal.

2. What roles are critical for a statewide Health Information Exchange (HIE)?

- State – Maintain state level NPI and make sure collisions are handled appropriately
- Centralized roles = heightened attention/focus on governance
- Decentralize roles = Heightened focus on connectivity
- Advisory council critical
- Governance must ensure broad representation – Hospitals; physicians; consumers; vendors; state agencies; universities; behavioral health must be integrated rather than in silos; and nursing home care must be integrated.
- Implementation/operational roles
- Role of hospitals in extending into the communities around them
- Who own the connectivity infrastructure – fiber broadband, telehealth
- State mandates/incentives regarding coverage in non-profitable areas to encourage private industry.
- Meaningful use
- HIE has a role in developing population based data & feedback to providers – health status info.
- Need to create an infrastructure that includes #1 technical support, education, planning, and training, monies of course.
- Statewide HIE needs to be like an umbrella – to cover areas of the state that aren't covered by regional efforts.
- Serve as broker between regional HIEs
- Consider opportunities for studying outcomes from data collected
- Consider developing statewide goals for quality initiatives, facilitating local groups getting there.
- Establishing models for privacy, data use, etc.
- Define the standards for interoperatibility.
- Communication to all parties involved.
- Natural third party should administer HIE (someone that everyone trust)
- Gatekeeper/privacy role is safe, need both HIPPA and private regulations.
- Define very clear standards, for HIE that avoids as much as possible different interpretations.
- Care management is a local – role of HIE is to provide infrastructure
- Governance
- State's role as payer (benefits for improvements in care)
- Patient identification/resolution – MPI – state identification (DCN) (need a consistent secured identifier)
- State needs to work at national level for a national identifier.
- Critical role of providers as source of information.
- Advisory board – urban, rural, FQHC, RHC, large and small hospitals, provider groups (doctors, dentists, pharmacists)
- Communications strategy – website e-lists
- Security standards/ Compliance with HIPAA
- Technical standards
- Accountability for dollars spent on HIT/HIE
- Public/private partnerships – transparency, clear rules of engagement for a competitive process.
- Early decision on federated vs. non-federated model. Our opinion was federated would be preferred model.

- Rural must be represented!
- Rule must not be underestimated as to what they can provide or bring to table.
- Competitive process for advisory board. Does not need to be created by lobbyist! Board needs to represent a wide variety of fields not just large companies & large hospitals. Need RHC, CAH, FQHC, CHC, pharmacy, not all universities.

3. What are you most concerned about related to Health Information Exchange (HIE)?

- Needs to be patient-focused for their benefit.
- Should not be owned by a single vendor or small group of vendors.
- Needs to align with meaningful use
- Needs a thorough audit trail and requests to exchange need routine state audits and independent auditor for state
- Rural internet connectivity
- Sustainability – realign benefit with investors/payers
- Privacy/security, particularly around behavioral health, aggravated by consumer paranoia Plus role of PEHR
- Fit with workflow: value has to be immediately evident to the direct provider
- Over-reliance on billing info as a substitute for clinical information (e.g. ICD is relatively useless from a clinical prospective)
- Inter-operability within the time-frames given may be unrealistic
- Meaningful use criteria are set too high and will impede adoption
- Reimbursement mechanisms are huge impediments
  - Existing revenue streams do not encourage HIT/HIE adoption
- Necessary change for and in regulations & policies – the time consumed in developing legislative language may delay the process
- Need for competitive cooperation
- Change in role of providers – must assume responsibility for specificity of patient information
- How are safety/security consideration addressed to the public
- Costs assumed by providers in changing their vendor platforms to comply with HIE inoperability requirements – may require a forum to create power position for discussion
- Privacy and confidentiality
- Accessibility
- Sustainability – who pays for upgrades support
- Lack of supporting documentation
- Funding for local (rural) public health departments
- Who pays
- Who is accessing who's information
- People may have concerns that their private information is being shared with non-health professionals.
- Hackers
- Concern that it won't be used by providers on a daily basis – will only be used for "extreme" patients – need to have true interoperability so providers won't have to access multiple sources of information
- Info systems need to be able to draw in HIE information
- Keeping legislators informed from the beginning – this will be a multi-year initiative – leadership needs to be involved. Concern is that legislature will fail to pass necessary legislation.
- Concern that consumers' voices won't be included in the planning/governance process
- Concerned about a viable business model – sustainability
- Privacy and security issues for consumers
- Concern that statewide efforts may hinder local efforts
- Concern that local exchanges won't cooperate with each other.

- Privacy and security
- Interoperability between federal data and all other systems (state, federal & local)
- Cost and sustainability from a legislative cost
- Timeliness of receiving data
- Rural/small private providers do not choose/or cannot afford to pay for HER/Electronic Health infrastructure
- Explicit consent from patients responding HIE
- Behavioral health care
- Alcohol & drug abuse must be treated separately/specifically
- Nursing homes – getting long-term care agencies to participate, no funding
- Ability to connect disparit, existing state systems – integration required
- Ability to connect to/ interface with other states.
- MO is starting late
- What is the role of payers within the HIE? What level of access to data will they have? Will they contribute/fund HIE
- Security & technical issues of sharing HC information. Assurance of HIPAA compliance
- Concerned about politics of Democrats vs. Republicans etc. and that it will prevent implementation
- Concerned about losing momentum of current HIT/HIE projects during this planning phase. Currently 16-17 in appropriated for HIE implementation/planning.
- Fear of not having outcomes & results for the monies spent.
- How will system be sustained? How will monthly fees be determined? Will organizations be required to pay for existing interchange(s) as well as new statewide interchanges. Also concerned extra staff time will be required for this.
- Would all states interchanges be interoperable as well?
- Providers shouldn't have to access multiple systems – won't happen in practice.
- Concerned about politics & lobbyists halting everything for their own agenda.
- Board should create & govern & Board needs to be 3-year term to not get complacent.
- A statewide association does not represent everyone so please do not turn to one association to represent.
- Need competition & RFP that is competitive not a predetermined piece.

4. What general comments do you have related to Health Information Exchange (HIE)? What other questions do you have?

- Can we do baby steps and pilots, case studies with quality measures? (Objective measure to measure HIE success)
- Build it and they will come.
- Focus on clinical data and integration into workflow.
- Reimbursement mechanisms today are not well synchronized & must be aligned at the provider level.
  - Pay for care coordination
  - Pay for care outcomes rather than widgets
  - Payers/vendors helping to subsidize adoption/implementation as a precondition to contracting.
- How will you evaluation the effectiveness of HIE implementation?
- What communication methods are being considered to move all parties along evenly in the HIE grant application process?
- How does HIPPA relate to HIE?
- How can we communicate with each state?
- How will we identify individuals when social security numbers are stolen identity?
- Can we access our own information? Meaningful use.
- Levels of accessibility? Who gets to view what/whose information?
- Are they going to pilot program?
- Have an EMR that we can link before the whole system is up and going.
- Is this system going to be linked to re-imbursement levels? Will agencies be "forced: to participate?
- Funeral homes – birth and death certificates.
- How will individuals see value?
- Information should be pushed to the provider for easy access.
- Individual providers should not have to access multiple HIEs.
- The need of a long-term road map; with pressures of immediate needs.
- Statewide claims – How will this affect hospitals having to be in place by 2011?
- Have there been planning associated with information technology? And coordination?
- Sustain ability model: claims processing through a single clearinghouse – eligibility verification (
- How do we hold providers responsible for using the HIE? (to realize cost/care benefits of HIE access.)
- The challenges around rural connectivity/point-to-point/high speed.
- How do we use/measure the affect of the HIE on quality of care?
- What is the timeline for getting proposals & committees organized?
- Make sure any IT vendor is selected thru a competitive RFP process. Have a committee that is consistent with the advisory committee to create RFP & disseminate & choose the IT vendor.
- Why not have the advisory committee go and visit other states' best practices.
- Outcomes?

- Should we consider Newt Gingrich's idea about consolidating transaction processing to help achieve efficiencies & savings to support HIT, HIE & meaningful use to improve quality and Believe there are states who have done this. Once board is created, we might want to visit them & see how they implemented.